

EDITORIALS

Some Thoughts on the Competence and Performance of Physicians

OF LATE there has been increasing interest in the competence of physicians and in how competently they actually perform in their practice situations. This interest has been within the medical profession and also in the public domain. It has been stimulated by the tremendous growth in medical knowledge, and the need to assure patients, the profession and the public that physicians are in fact keeping up with this progress. This has led to much attention being given to just what are the components of competence for a physician in practice, how can competence and performance in practice be measured by the physician or anyone else, and what part does informal, formal or mandated continuing medical education play in all of this. The answers are not nearly as simple as the uninitiated might think. The discussions at a recent two-day meeting of the Alliance for Continuing Medical Education (ACME) probed some of the questions and gave rise to some of the thoughts presented here.

- *How do practicing physicians learn or keep up?* It is suggested that physicians learn from their own practice experience, from professional peers and from academia. Learning from practice experience accumulates during a lifetime of practice and forms a personal data base of clinical experience. Learning from peers is generally unstructured and usually occurs around problems in patient care. Knowledge derived from academia is acquired in concentrated fashion during formal undergraduate and specialty training, and then becomes outdated unless steps are taken to pre-

vent this from happening by means of formal or informal continuing medical education. It is probable that formal CME plays a relatively minor role compared with informal or self-directed physician learning.

- *Who is responsible that a physician remains competent and performs competently?* It turns out that this can only be the individual physician, and that this responsibility is to self, to patients, to the profession and to the public, which grants a license to practice on the basis of presumed competence. It also turns out that the responsibility to self is the sine qua non for all the others, and that this is a function of personal character—honesty, integrity, self-discipline and a sense of duty—all qualities which are unlikely to be taught or mandated. Moreover, if these qualities are not present, the likely result will be poor or incompetent practice performance. It is seldom indeed that they can be acquired through education or by accumulating formal or mandated continuing education credits.

- *How does physician competence and performance relate to the practice situation?* In medical school physicians acquire a framework of basic knowledge and skills which are needed to enter virtually any specialty. In a sense their competence is plenipotential. Specialty training narrows this potential competence to certified competence in a particular specialty while at the same time the potential for competence in other specialties diminishes. During a lifetime of practice further narrowing takes place until each individual physi-

cian develops an essentially unique individual practice which may be shared by a few other physicians at the most. A physician is expected to be competent and able to perform competently at whatever level of practice differentiation he or she may have reached at any particular time.

- *Are knowledge, skills and good character all that are necessary for continuing physician competence?* It is becoming recognized that continual learning, though essential, is not sufficient. A competent physician must also take into account any personal limitations due to mental and physical aging processes, and also attend to whatever stress factors may be present in his or her own personal or practice life. Many are coming to believe that physicians owe it to patients, peers and the public to maintain mental and physical competence (some might say fitness) and to practice only within this competence. This also suggests attention to personal life style and habits of work and recreation.

There seem to be quite clear messages emerging from such considerations as the above. Physician competence and performance are far more an individual matter than many might first suspect. Neither is ever static. Rather what constitutes competence and competent performance continuously changes with medical progress and is different for each stage in the continuing differentiation of each physician's practice, and therefore for each individual practice situation at any given time. It develops that the focus of responsibility for maintaining competence and also for monitoring performance actually lies with each individual physician. It seems reasonable that soon the trend will be toward more self-study of competence and performance and more self-directed learning to maintain competence and to improve performance. It appears that the role of professional educators (including academia) and professional organizations will be more to assist with self-study of performance and with self-directed learning or behavior change, in a way much as power-assisted steering in an automobile may assist the self-directed driver to stay on the road and reach his destination. The role of government will be more to promote these self-directed activities, encourage professional and academic support of them, and then to concern itself primarily with the identification, elimination, or rehabilitation (when possible) of those relatively few physicians who cannot or

do not practice within a framework of accountability and are found by legal processes to be unfit for the responsibilities of patient care.

—MSMW

Chlamydiae: Exotic and Ubiquitous

DURING THE 1970's *Chlamydia trachomatis* received attention.¹ The report by Covelli, Husky and Dolphin elsewhere in this issue serves as a useful reminder that the other species within the genus, *C psittaci*, is still with us. Psittacosis in humans is contracted by exposure to infected avian species. The clinical spectrum is quite broad; many patients will have a disease which cannot be distinguished clinically from Legionnaires' disease. The two diseases, however, can be diagnosed and readily differentiated by serologic testing. Although infections in humans can be contracted from exposure to feral birds, most infections result from exposure to pet birds or from occupational exposure in the poultry industry. Occupational exposure is difficult to control but many chlamydial infections in exotic pet birds could be prevented if the birds received effective chemoprophylaxis before sale. Exotic avian species imported into the United States are required to undergo a quarantine during which they receive chlortetracycline in their feed. Unfortunately, this system is an administrative failure. There is no supervision to insure that the birds receive adequate amounts of the drug. Routine monitoring of blood levels, to assure that adequate chlortetracycline concentrations are obtained, would probably prevent dissemination of infected birds and subsequent human infections.²

Psittacosis in humans is relatively uncommon—approximately 100 cases were reported to the Center for Disease Control (CDC) in 1979. Human infections with *C trachomatis*, however, number in the millions. In the past decade many of the clinical epidemiologic studies of *C trachomatis* infections stressed their etiologic role in 30 percent to 50 percent of nongonococcal urethritis (NGU). NGU has received much attention because it is a clinical syndrome that can be reasonably well defined. We are now reaching the stage where we can appreciate that NGU is probably least im-